Notification of a Collaborative Agreement for the Advanced Registered Nurse Practitioner's Prescriptive Authority for Controlled Substances (CAPA –CS)

By signing and submitting this form to KBN, I hereby certify that I am nationally certified as an Advanced Registered Nurse Practitioner and have been registered, certified, or licensed as an Advanced Registered Nurse Practitioner in good standing for one (1) year in Kentucky or in another state prior to applying for licensure in Kentucky.

This notification meets the requirements of KRS 314.042 and 201 KAR 20:057. A CAPA-CS was entered into by the following Advanced Registered Nurse Practitioner (ARNP) and physician on _____.
Date

All information on this notification form must be completed or the notification form will be returned to you for completion.

ARNP Last Name (print clearly)

Physician Last Name (print clearly)

ARNP First Name (print clearly)

Physician First Name (print clearly)

ARNP Registration #

License #

Certification Specialty

Specialty

ARNP Signature

Physician Signature

Date Signed

Date Signed

Name of Practice

Address of Practice

City State Zip Code

Phone Number (_____) _____
include area code

Upon completion of this form, please return to:

Kentucky Board of Nursing
312 Whittington Parkway
Suite 300
Attn: ARNP Licensure Specialist
Louisville, KY 40222

8/2006 rk